Introduction

The Agency for Healthcare Research and Quality (AHRQ) annually publishes a wealth of information in its congressionally mandated National Healthcare Quality Report (NHQR). This *State Snapshot* series provides quick and easy access, through the Web (http://www.qualitytools.ahrq.gov/qualityreport/state/spf.aspx), to the many measures and tables of the NHQR from a State-specific perspective.

Each *Snapshot* shows two areas in which the health care system of a particular State (or the District of Columbia) is doing well and two in which it might be able to improve. The examples are chosen from those measures for each State that score above average and below average, respectively, relative to all reporting States. Much more information can be viewed on the Web through the *Snapshot* series (at the address above). The *State Summary Tables* list over 100 measures, most with estimates for 2 years of data, for each State, when available from the NHQR.

Data sources, statistics used to assign the categories, calculation of averages, and criteria for selecting the examples presented below are explained at http://www.qualitytools.ahrq.gov/qualityreport/state/method.aspx.

Tennessee Overview

The *Tennessee Summary Table* includes 106 measures from the most recent year of data in the 2004 NHQR (http://www.qualitytools.ahrq.gov/qualityreport/state/stateData.aspx?state=TN). For the most recent data year, Tennessee has 12 measures in the above-average category (compared to all reporting States), 43 in the average category of States, and 32 in the below-average category of States. Tennessee has 19 measures without sufficient data for classification. Measures in the below-average, and possibly in the average, categories indicate areas that may be fruitful for quality improvement initiatives.

Where Tennessee Does Well (Examples)

In this section, the examples show a few of the measures for which the Tennessee result was in the above-average group of States. For some measures, such as screening rates, the highest rate is the best result; and for other measures, such as time to treatment, the lowest rate is the best. The above-average category includes the best results however measured. A rate is considered above average when it is better than the all-State average and is statistically different from the all-State average. The all-State average reflects all States, including the District of Columbia, with available data for the measure.

A benchmark for quality improvement is provided below—the top-10-percent State average. This is the average for the five States that have the highest rates among all reporting States and the District of Columbia, 51 jurisdictions. The benchmark shows the best results attained under current medical practice. Some States may view that as a goal for improvement or may set more ambitious goals.

Example 1: Percent of adults 65 and older receiving flu vaccine in the last year

Most recent data year	Top-10-percent State average	All-State average	Bottom-10-percent State average	Tennessee
2002	76.5	69.2	58.5	75.5

- This measure shows how effectively the health care system vaccinates patients age 65 and over against the flu. The higher the State estimate for this measure, the better the protection of the elderly population against influenza in the State.
- In 2002, 75.5 percent of persons age 65 and over in Tennessee had received an influenza vaccination in the past 12 months. This was roughly equivalent to the top-10-percent State average of 76.5 percent.
- Tennessee's estimate for this measure was above average for the most recent year (2002). This represented an improvement from Tennessee's estimate in 2001, when it was only average.
- To view all States on this measure in the 2004 NHQR, see Appendix Table 1.79b.

Example 2: Percent of people, covered by managed-care Medicare, who said health care providers always showed respect for what they had to say

Most recent data year	Top-10-percent State average	All-State average	Bottom-10-percent State average	Tennessee
2002	77.0	71.4	61.8	77.8

- This measure shows, from the viewpoint of adults under Medicare managed care, whether health care providers showed respect for what they had to say. The higher the State estimate for this measure, the more adults under Medicare managed care in the State believe that their health providers always respect what they say.

- In 2002, 77.8 percent of adults age 18 and over in Tennessee who were covered by Medicare managed care and reported going to a doctor's office or clinic indicated that their provider respected what they had to say. This was roughly equivalent to the top-10-percent State average of 77 percent.
- Tennessee's estimate for this measure was above average for both the most recent year (2002) and the initial year (2001).
- To view all States on this measure in the 2004 NHQR, see Appendix Table 4.5g.

Where Improvement May Be Needed (Examples)

The examples in this section are measures for which the Tennessee result was in the below-average group of States. To understand how to use these results, see the following section (How To Use the Information). How results on each measure are classified into the below-average category is described at http://www.qualitytools.ahrq.gov/qualityreport/state/method.aspx.

The bottom-10-percent State average is provided as a parallel to the top-10-percent State average. Comparison of the two averages shows how far the five States with the lowest rates have to improve to achieve the results of the five States with the best rates.

Example 3: Percent of women receiving prenatal care in first 3 months of pregnancy

Most recent data year	Top-10-percent State average	All-State average	Bottom-10-percent State average	Tennessee
2001	89.8	83.6	76.1	82.8

- This measure shows the extent to which women get prenatal care in the first 3 months of pregnancy. The higher the State estimate for this measure, the earlier care is provided to pregnant women in the State.
- In 2001, 82.8 percent of pregnant women in Tennessee received prenatal care in the first trimester. This was roughly equivalent, when the statistical error of the estimates is considered, to the bottom-10-percent State average of 76.1 percent. The top-10-percent State average was 89.8 percent.
- Tennesee's estimate was below average for the most recent year (2001). This repesented a decline from 1998, when Tennessee's estimate was above average.
- To view all States on this measure in the 2004 NHQR, see Appendix Table 1.56b.

Example 4: HIV-infection deaths per 100,000 population

Most recent data year	Top-10-percent State average	All-State average	Bottom-10-percent State average	Tennessee
2001	1.2	3.4	10.6	4.8

- This measure shows the number of deaths from HIV per 100,000 people. The lower the State estimate for this measure, the fewer HIV-related deaths occur in the State. This

lower death rate could be explained by effective treatment or a low incidence of HIV among the State population.

- In 2001, there were five HIV-infection deaths per 100,000 people in Tennessee. This rate was below the all-State average of three HIV-infection deaths per 100,000 people. The top-10-State average was one.
- Tennessee´s rate for this measure was below average for both the most recent year (2001) and the initial year (1999).
- To view all States on this measure in the 2004 NHQR, see Appendix Table 1.55b.

How To Use the Information

The NHQR offers a rare opportunity for States and the District of Columbia to view their health care systems in comparison to other State systems on about 100 quality measures. All States have measures in both the above-average and the below-average groups. A first step to determining whether and in which areas quality improvement should be fostered in a State is to study measures in the State Summary Table (http://www.qualitytools.ahrq.gov/qualityreport/state/statedata.aspx?state=TN). Understanding what these measures mean will require insight from many experts familiar with the health care system in the State as well as with quality measurement and improvement strategies. It may also require more study and data collection to determine that a problem actually exists or to identify underlying problems and possible solutions. For example, factors that affect specific population subgroups may underlie apparent health care quality problems and may thus require outreach focused toward those groups. Health care processes also may contribute to poor results, and thus quality improvement may require change in behavior of health care providers. AHRQ hopes that these data aid Tennessee leaders in exploring the quality of health care in their jurisdiction and in working to improve it.

For More Information

State Snapshots and State Summary Tables for each State are available on the Internet at http://www.qualitytools.ahrq.gov/qualityreport/state/spf.aspx. For additional information on this topic, please send e-mail to QRDRInquiries@ahrq.gov.

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